HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

HEREDITARY ANGIOEDEMA AGENTS PRIOR AUTHORIZATION FORM (*form effective 7/15/2024*)

Prior authorization guidelines for **Hereditary Angioedema (HAE) Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnoses (*submit documentation*):		Dx codes (*required*):	
What is the beneficiary's weight?		_____ kg / lbs	
Has the beneficiary been taking the requested medication within the past 90 days?		☐Yes ☐No	*Submit documentation and date of last dose.*
Is the requested medication prescribed by or in consultation with an allergist/immunologist, dermatologist, or hematologist?		☐Yes ☐No	*Submit documentation of consultation, if applicable.*
Will the beneficiary be using the requested medication with any other HAE Agents for the same indication (ie, more than 1 HAE Agent for acute treatment OR more than 1 HAE Agent for long-term prophylaxis)?		☐Yes – please list: _____ _____ ☐No	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

☐Requested medication is being used for short-term prophylaxis (e.g., surgical or dental procedure)

☐Has a diagnosis of **HAE Type I or Type II** (with C1 inhibitor deficiency/dysfunction) AND:

☐ Has a low C4 complement level (mg/dL) obtained on 2 separate occasions

☐ At least one of the following:

☐ Has a low C1 esterase inhibitor antigenic level (mg/dL) obtained on 2 separate occasions

☐ Has a low C1 esterase inhibitor functional level (<65% [unless already using an androgen or C1 esterase inhibitor]) obtained on 2 separate occasions

☐ Has a diagnosis of **HAE Type III** (with normal C1 inhibitor) AND:

☐ Has a normal C4 complement level (mg/dL)

☐ Has a normal C1 esterase inhibitor antigenic level (mg/dL)

☐ Has a normal C1 esterase inhibitor functional level

☐ Has a history of recurrent angioedema without urticaria

☐ One of the following:

☐ Both of the following:

☐ Has a family history of HAE

☐ Failed to respond to maximum recommended doses of antihistamines (eg, cetirizine 20 mg twice daily)

☐ Has an HAE-causing genetic mutation

☐ One of the following:

☐ Is not taking an estrogen-containing medication (hormone replacement, contraceptives, etc.)

☐ Is taking an estrogen-containing medication (hormone replacement, contraceptives, etc.) that is medically necessary for the beneficiary's indication – specify indication: _____

☐ Is not taking an ACE inhibitor (benazepril, enalapril, lisinopril, quinapril, ramipril, etc.)

☐ Is using the requested medication for **long-term prophylaxis** AND:

☐ Has poorly controlled HAE despite use of an HAE Agent for on demand/acute treatment

☐ **For a non-preferred HAE Agent:**

☐ Has a history of trial and failure of or contraindication or intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.)*

RENEWAL requests

☐ Is using the requested medication for **long-term prophylaxis** AND:

☐ Experienced fewer HAE attacks since starting the requested medication

☐ Is using the requested medication for **acute treatment** AND:

☐ Experienced a positive clinical response to the requested medication

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: